Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005079	A. BUILDING: _____ B. WING _____	02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOS	2401 UNIVERSITY AVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00137027 Substantiated: No deficiencies cited. Date: 2-24-14 Facility Number: 005079 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Indiana University Health Ball Memorial Hospital is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Indiana Hospital Licensure rules. QA: claughlin 03/05/14	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE